STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005089	A. BUILDING: _____ B. WING _____	03/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S MEDICAL CENTER	3700 WASHINGTON AVE EVANSVILLE, IN 47750

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of a State complaint. Complaint Number: IN00163575 Unsubstantiated; Lack of Sufficient Evidence. Date of survey: 3/16/15 Facility number: 005089 St. Mary's Medical Center is in compliance with 410 IAC 15-1.5-6, Nursing service, Hospital Licensure Rules. QA: cjl 04/17/15	S 000		